

No. 300
10-47
5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

31558
7890

FILED SEP 20 1948

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No.

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether years, months or days)

In this community 15 YRS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 12

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 204 South Garrison
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Hattie Young

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3
year 1948 hour 9 minute 55 P. M.

21. I hereby certify that I attended the deceased from August 30, 1948 to Sept. 3, 1948
that I last saw her alive on Sept. 3, 1948
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race negro

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: unknown
(Month) (Day) (Year)

Immediate cause of death: Cerebral thrombosis
Duration: Undet.

Due to _____

Due to _____

Other conditions: Undetermined
(Include pregnancy within 3 months of death)

8. AGE: Years 48 Months _____ Days _____ If less than one day hr. _____ min. _____

Major findings:
Of operations _____

Of autopsy: None

PHYSICIAN: _____
Underline the cause to which death should be charged statistically.

9. Birthplace: Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation: Domestic

MOTHER FATHER

11. Industry or business: unknown

12. Name: unknown

13. Birthplace: Miss.
(City, town, or county) (State or foreign country)

14. Maiden name: unknown

15. Birthplace: Miss.
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify place) (4) Means of injury _____

23. Signature: Alco J. Daniels (M. D. or other) _____
Address: 2601 N Whittier Date signed: 9/7/48

16. (a) Informant: Mattie Washington

(b) Address: 3018 Clark Ave

17. (a) Burial (b) Date thereof: 9-9-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Washington Park

18. (a) Signature of funeral director: Alvin Broz

(b) Address: 3644 Finley Ave

19. (a) SEP 8 1948 (b) J. J. Breeseck
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Louis V. Atkins

Licensed Embalmer No. *2842*

P. O. Address *3644 Finney*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.